

300527

STATE OF SOUTH CAROLINA

(Caption of Case)

Example: Application for a Class C Charter Certificate from
John Doe dba Doe's Limo

BEFORE THE
PUBLIC SERVICE COMMISSION
OF SOUTH CAROLINA

TRANSPORTATION COVER SHEET

DOCKET
NUMBER: 2021 - 184 - T

If this is your first time filing an application with the PSC, you will not have a Docket Number. The Commission will assign one to you. If you have filed with the Commission before, a Docket Number was assigned and should be entered above.

Jasmine Marzyck
(Please type or print)

Submitted by: Jasmine Marzyck

Address: 342 Allans Mill Dr,
Columbia, SC 29223

Telephone: 803-404-1681

Fax: _____

Other: _____

Email: jazzmarzyck@yahoo.com

NOTE: The cover sheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for use by the Public Service Commission of South Carolina for the purpose of docketing and must be filled out completely.

NATURE OF ACTION (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Application - Class A/A Restricted | <input type="checkbox"/> Request for Name Change on Certificate |
| <input type="checkbox"/> Application - Class C Taxi | <input type="checkbox"/> Request to Amend Scope of Authority |
| <input type="checkbox"/> Application - Class C Charter | <input type="checkbox"/> Request to Amend Tariff (rate increase, etc.) |
| <input type="checkbox"/> Application - Class C Charter Bus | <input type="checkbox"/> Request to Amend Passenger Limit |
| <input checked="" type="checkbox"/> Application - Class C Non-Emergency | <input type="checkbox"/> Request |
| <input type="checkbox"/> Application - Class C Stretcher Van | <input type="checkbox"/> Exhibit |
| <input type="checkbox"/> Application - Class E Household Goods | <input type="checkbox"/> Late-Filed Exhibit |
| <input type="checkbox"/> Application - Class E Hazardous Waste | <input type="checkbox"/> Letter |
| <input type="checkbox"/> Application | <input type="checkbox"/> Proposed Order |
| <input type="checkbox"/> Request for Extension to Comply with Order | <input type="checkbox"/> Publisher's Affidavit |
| <input type="checkbox"/> Request for Order Granting Authority to Obtain a Certificate of Public Convenience and Necessity to be Rescinded | <input type="checkbox"/> Reservation Letter |
| <input type="checkbox"/> Request for Cancellation of Certificate | <input type="checkbox"/> Response |
| <input type="checkbox"/> Request for Suspension | <input type="checkbox"/> Return to Petition |
| <input type="checkbox"/> Request for Reinstatement | <input type="checkbox"/> Other: _____ |

RECEIVED

JUN 01 2021

PSC SC
MAIL / DMS

jo

If you have any questions about this form, please contact the PUBLIC SERVICE COMMISSION at 803-896-5100.

PUBLIC SERVICE COMMISSION OF SOUTH CAROLINA
101 Executive Center Drive, Suite 100
Columbia, South Carolina 29210

Phone: (803) 896-5100 Fax: (803) 896-5199

APPLICATION FOR CERTIFICATE OF PUBLIC CONVENIENCE AND NECESSITY FOR
OPERATION OF MOTOR VEHICLE CARRIER

CLASS C - NON-EMERGENCY

Date: 5/21/21

Application is hereby made for a Certificate of Public Convenience and Necessity, in accordance with the provision of S.C. Code Ann., § 58-23-10, et seq. (1976), and amendments thereto.

1. Mazyck Medical Transport LLC

Name under which business is to be conducted (corporation, partnership, or sole proprietorship, with or without trade name.)

342 Allans Mill Dr, Columbia SC 29223

Street Address of Applicant

Mailing Address of Applicant (if different from street address)

803-404-1681

Phone

Fax

Mazyckmedical@gmail.com

Email Address

2. If the Applicant is an LLC or a corporation, a copy of the Certificate of Existence from the South Carolina Secretary of State and the Articles of Incorporation must be attached. (If incorporated outside of SC, attach South Carolina Secretary of State "Foreign Corporation" Certificate.)

3. Select Entity Type: (Check one)

☒ Individual Owner/Sole Proprietorship

☐ Partnership - List names and address of all person having an interest in the business.

☐ Corporation - List names and addresses of two principal officers.

Applicant is financially able to furnish the services as specified in this application and submits the following statement of assets and liabilities.

Financial Statement

Applicant's assets and liabilities are as follows:

<u>Assets:</u>		<u>Liabilities:</u>	
Value of Real Estate	<input type="text" value="0"/>	Mortgage/Loan on Real Estate	<input type="text" value="0"/>
Value of Motor Vehicles	<input type="text" value="0"/>	Loans Owed on Motor Vehicles	<input type="text" value="0"/>
Cash on Hand	<input type="text" value="0"/>	Business/Other Loans Owed	<input type="text" value="0"/>
Cash in Bank	<input type="text" value="0"/>	Other Liabilities or Debts	<input type="text" value="0"/>
Value of Other Assets and Equipment	<input type="text" value="\$ 750"/>	Total Liabilities	<input type="text" value="0"/>
Total Assets	<input type="text" value="\$ 750"/>		

INSTRUCTIONS:

1. "Value of Real Estate" means the actual or estimated market value of any real property/buildings owned by the Company/Business Applying for a Certificate.
2. "Mortgage/Loan on Real Estate" means the outstanding balance on any Mortgage, Equity Line or other Loan secured by the Real Estate listed in Item 1.
3. "Value of Motor Vehicles" means the actual or fair estimated value of any moving vans, trucks or other vehicles owned by the Company/Business Applying for a Certificate.
4. "Loans Owed on Motor Vehicles" means the outstanding balance on any loans or liens on the vehicles listed in Item 3.
5. "Cash on Hand" is the total of actual cash held by the Company/Business applying for a Certificate on the day this form is filled out.
6. "Business/Other Loans Owed" means the outstanding balance on any small business loan or other unsecured loan made by a person, bank or business to the Business/Company applying for a Certificate.
7. "Cash in Bank" means the current balance in checking accounts, savings accounts or the like in the name of the Company/Business applying for a Certificate. Do not include retirement accounts or personal bank account balances.
8. "Value of Other Assets and Equipment" should include the actual or estimated value of items such as office equipment (computers/furnishings), moving equipment (hand trucks/blankets/strapping), and trailers.
9. "Other Liabilities or Debts" means specific amounts/balances which the Company/Business applying for a Certificate knows that it owes to other persons or companies; for example Franchise Fees. This does NOT include regular bills such as electricity bills, security system costs, insurance, salaries, etc.

PROPOSED RATES AND CHARGES FOR SERVICE

Proposed Rates and Charges:

\$ 221.72 per ride + \$ 7.42 per mile

Requested Scope of Authority: Check all counties in which you are requesting permission to operate.
You will only be allowed to operate in those counties checked below. You may request "Statewide" authority if you intend to operate in all counties in South Carolina.

- | | | | | |
|--|---------------------------------------|--|---|---|
| <input type="checkbox"/> Abbeville | <input type="checkbox"/> Cherokee | <input type="checkbox"/> Florence | <input type="checkbox"/> Lee | <input type="checkbox"/> Saluda |
| <input type="checkbox"/> Aiken | <input type="checkbox"/> Chester | <input checked="" type="checkbox"/> Georgetown | <input checked="" type="checkbox"/> Lexington | <input type="checkbox"/> Spartanburg |
| <input type="checkbox"/> Allendale | <input type="checkbox"/> Chesterfield | <input type="checkbox"/> Greenville | <input type="checkbox"/> Marion | <input type="checkbox"/> Sumter |
| <input type="checkbox"/> Anderson | <input type="checkbox"/> Clarendon | <input type="checkbox"/> Greenwood | <input type="checkbox"/> Marlboro | <input type="checkbox"/> Union |
| <input type="checkbox"/> Bamberg | <input type="checkbox"/> Colleton | <input type="checkbox"/> Hampton | <input type="checkbox"/> McCormick | <input type="checkbox"/> Williamsburg |
| <input type="checkbox"/> Barnwell | <input type="checkbox"/> Darlington | <input checked="" type="checkbox"/> Horry | <input type="checkbox"/> Newberry | <input type="checkbox"/> York |
| <input type="checkbox"/> Beaufort | <input type="checkbox"/> Dillon | <input type="checkbox"/> Jasper | <input type="checkbox"/> Oconee | |
| <input checked="" type="checkbox"/> Berkeley | <input type="checkbox"/> Dorchester | <input type="checkbox"/> Kershaw | <input type="checkbox"/> Orangeburg | <input checked="" type="checkbox"/> Statewide |
| <input type="checkbox"/> Calhoun | <input type="checkbox"/> Edgefield | <input type="checkbox"/> Lancaster | <input type="checkbox"/> Pickens | |
| <input checked="" type="checkbox"/> Charleston | <input type="checkbox"/> Fairfield | <input type="checkbox"/> Laurens | <input checked="" type="checkbox"/> Richland | |

DESCRIPTION OF EQUIPMENT

You are **not** required to own a vehicle to file an application. However, prior to being issued a certificate by ORS, you will be required to have obtained a vehicle.

Maximum Number of Passengers Vehicle is Equipped to Carry: (The number of passengers a vehicle is equipped to carry is based on the number of **seatbelts** in the vehicle, including the driver's seatbelt.)

- ☒ 1-7 Passengers, including driver
- ☐ 8-15 Passengers, including driver

MAKE	YEAR & MODEL	VIN#	EMPTY WEIGHT	WHEEL- CHAIR LIFT

INSURANCE QUOTE

This form **MUST BE COMPLETED.**

The insurance quote must be complete, listing current insurance premiums. At the discretion of the Commission, a copy of current insurance policies may be required. Do not provide a copy of insurance policies unless requested. You will not be required to purchase insurance until your application has been approved and an order has been issued by the PSC. THIS IS ONLY A QUOTE.

The following insurance quote is for:

Name of Applicant

Address of Applicant

Amount of Premium:

Liability Insurance \$ _____

The above quoted premium is for a term of _____ months.

Minimum Limits - Bodily injury and property damage limits will not be less than the following:

See attached
Limits Quoted

Liability Combined Each Occurance	\$ 1,000,000	
Medical Payments per Person	\$ 1,000	

Name of Insurance Company

Home Office Address of Company

I, the Applicant, am familiar with the Commission's Rules and Regulations relating to insurance requirements and the above quote meets the minimum insurance limits prescribed. The insurance company making this quote is authorized by the South Carolina Department of Insurance to do business in South Carolina.

NOTICE:

If you wish to self-insure your motor vehicles for liability and property damage, you must comply with S.C. Code Ann. Sections 56-9-60 and 58-23-910. For more information, contact the Department of Motor Vehicles at (803) 896-8457 or (803) 896-9903.

If you wish to apply as a self-insured for worker's compensation coverage in South Carolina you may do so with the South Carolina Worker's Compensation Commission (WCC) provided that you will be able to: 1) post a surety bond or letter-of-credit with the WCC for a minimum of \$500,000, 2) agree to pay a yearly self-insurance tax, and 3) agree to pay an annual assessment to the South Carolina Second Injury Fund. For more information, contact the WCC Self-Insurance Division at (803) 737-5712 or on the web at www.wcc.state.sc.us/self-insurance.

Exhibit Fit, Willing, and Able (FWA)

Name

1. Is there currently any outstanding judgments against the Applicant?

☐ Yes ☒ No

If Yes, list judgements here:

2. Is Applicant familiar with all statutes and regulations, including safety regulations and governing for-hire motor carrier operations in South South Carolina, and does Applicant agree to operate in compliance with these statutes and regulations?

☒ Yes ☐ No

3. Is Applicant aware of the Commission's insurance requirements and the insurance premium costs associated therewith?

☒ Yes ☐ No

Exhibit on Driver Qualifications

1. Applicant understands that drivers must possess at least a current American Red Cross Standard First Aid and CPR Certificate or its equivalent, and records that verify/record such training must be kept on file at the company's primary place of business within South Carolina.

☒ Yes☐ No

2. Applicant understands that drivers must be in compliance with all OSHA regulations.

☒ Yes☐ No

3. Applicant understands that drivers must be trained in the use of all vehicle installed safety equipment such as two-way radios, first-aid kits, fire extinguishers, and other equipment as outlined in PSC Regulations.

☒ Yes☐ No

4. Applicant understands that drivers must be able to physically perform actions necessary to assist persons with disabilities, including wheelchair users.

☒ Yes☐ No

5. Applicant understands that drivers must wear a professional uniform and photo identification badge that easily identifies the driver and the company for whom the driver works.

☒ Yes☐ No

6. Applicant understands that drivers must complete twelve (12) hours of in-service training annually in the area of safety, and records that verify/record such training must be kept on file at the company's primary place of business within South Carolina.

☒ Yes☐ No

PUBLIC SERVICE COMMISSION OF SOUTH CAROLINA
101 EXECUTIVE CENTER DRIVE, SUITE 100
COLUMBIA, SOUTH CAROLINA 29210


Applicant is familiar with the provision of S.C. Code Ann. §58-23-10, et seq.(1976), and amendments thereto, and R.103-100 through R.103-241 of the Commission's Rules and Regulations for Motor Carriers (S.C. Code Ann. Regs., 1976), and R.38-400 through R.38-503 of the Department of Public Safety's Rules and Regulations for Motor Carriers (Volume 2, S.C. Code Ann., 1976) and amendments thereto, and hereby promises compliance therewith.

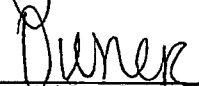
S.C. Code Ann. Section 58-3-250 states, in part, that every final order of the Commission must be served by electronic service, registered or certified mail, upon the parties to the proceeding or their attorneys.

Please check the applicable box:

- ☒ The Applicant AGREES to receive future Commission orders related to the Applicant's authority in South Carolina through the Commission's eService System. The Applicant authorizes the Commission to serve its orders by using the e-mail address as it appears on page one of this Application. To sign up for eService notifications, please visit www.psc.sc.gov to create a My DMS account.
- ☐ The Applicant DOES NOT AGREE to receive future Commission orders related to the Applicant's authority in South Carolina through the Commission's eService System.

The Applicant for the Certificate of Public Convenience and Necessity as set forth in the foregoing, swear or affirm that all statements contained in the above application are true and correct.


Applicant's Signature


Title of Applicant (e.g. President, Owner, etc.)

STATE OF SOUTH CAROLINA

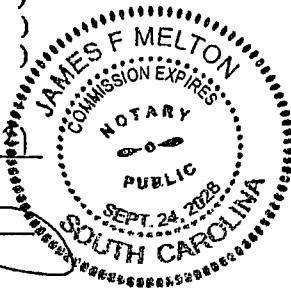
COUNTY OF Richland

SWORN TO BEFORE ME

This 1st day of June, 2021

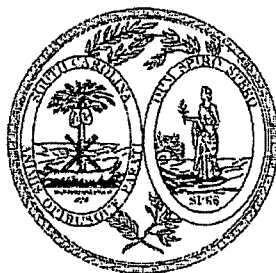

Notary Public

Commission Expires 9/24/28



Print Application

The State of South Carolina




Office of Secretary of State Mark Hammond

Certificate of Existence

I, Mark Hammond, Secretary of State of South Carolina Hereby Certify that:

Mazyck Medical Transport LLC, a limited liability company duly organized under the laws of the State of South Carolina on May 20th, 2021, with a duration that is at will, has as of this date filed all reports due this office, paid all fees, taxes and penalties owed to the State, that the Secretary of State has not mailed notice to the company that it is subject to being dissolved by administrative action pursuant to S.C. Code Ann. §33-44-809, and that the company has not filed articles of termination as of the date hereof.

Given under my Hand and the Great Seal
of the State of South Carolina this 21st day
of May, 2021.


Mark Hammond, Secretary of State

CERTIFIED TO BE A TRUE AND CORRECT COPY
AS TAKEN FROM AND COMPARED WITH THE
ORIGINAL ON FILE IN THIS OFFICE

May 21 2021
REFERENCE ID: 787018


SECRETARY OF STATE OF SOUTH CAROLINA

STATE OF SOUTH CAROLINA
SECRETARY OF STATE

ARTICLES OF ORGANIZATION
Limited Liability Company – Domestic

Filing ID: 210521-0631111

Filing Date: 05/20/2021

The undersigned delivers the following articles of organization to form a South Carolina limited liability company pursuant to S.C. Code of Laws Section 33-44-202 and Section 33-44-203.

1. The name of the limited liability company (Company ending must be included in name*)

Mazyck Medical Transport LLC

*Note: The name of the limited liability company must contain one of the following endings: "limited liability company" or "limited company" or the abbreviation "LLC", "LLC", "L.C.", "LC", or "Ltd. Co."

2. The address of the initial designated office of the limited liability company in South Carolina is
342 Allans Mill Dr

(Street Address)

Columbia , South Carolina 29223

(City, State, Zip Code)

3. The initial agent for service of process is

Jasmine Mazyck

(Name)

(Signature of Agent)

And the street address in South Carolina for this initial agent for service of process is:

342 Allans Mill Dr

(Street Address)

Columbia

(City)

South Carolina 29223

(Zip Code)

4. List the name and address of each organizer. Only one organizer is required, but you may have more than one.

(a)

Jasmine Mazyck

(Name)

342 Allans Mill Dr

(Street Address)

Columbia , South Carolina 29223

(City, State, Zip Code)

CERTIFIED TO BE A TRUE AND CORRECT COPY
AS TAKEN FROM AND COMPARED WITH THE
ORIGINAL ON FILE IN THIS OFFICE

May 21 2021

REFERENCE ID: 787018

Mark Hammond
SECRETARY OF STATE OF SOUTH CAROLINA

Mazyck Medical Transport LLC

Name of Limited Liability Company

(b)

Yolanda Mazyck

(Name)

471 South Santee Rd

(Street Address)

McClellanville, South Carolina 29458

(City, State, Zip Code)

5. ☐ Check this box only if the company is to be a term company. If the company is a term company, provide the term specified. _____
6. ☐ Check this box only if management of the limited liability company is vested in a manager or managers. If this company is to be managed by managers, include the name and address of each initial manager.

(a)

(Name)

(Street Address)

(City, State, Zip Code)

(b)

(Name)

(Street Address)

(City, State, Zip Code)

7. ☐ Check this box only if one or more of the members of the company are to be liable for its debts and obligations under Section 33-44-303(c). If one or more members are so liable, specify which members, and for which debts, obligations or liabilities such members are liable in their capacity as members. This provision is optional and does not have to be completed.

8. Unless a delayed effective date is specified, these articles will be effective when endorsed for filing by the Secretary of State. Specify any delayed effective date and time _____.

CERTIFIED TO BE A TRUE AND CORRECT COPY
AS TAKEN FROM AND COMPARED WITH THE
ORIGINAL ON FILE IN THIS OFFICE

May 21 2021
REFERENCE ID: 787018



SECRETARY OF STATE OF SOUTH CAROLINA

Mazyck Medical Transport LLC

Name of Limited Liability Company

9. Any other provisions not consistent with law which the organizers determine to include, including any provisions that are required or are permitted to be set forth in the limited liability company operating agreement may be included on a separate attachment. Please make reference to this section if you include a separate attachment.

10. Each organizer listed under number 4 must sign.

Jasmine Mazyck

Signature of Organizer

Date: 05/20/2021

Yolanda Mazyck

Signature of Organizer

Date: 05/20/2021

Account Summary For MAZYCK MEDICAL TRANSPORT LLC

BHHC
Quick

Quote #: 11740580

Status: Submitted

Policy Type: AP

Originally Quoted: 5/25/2021 7:58 PM EST
Quote Printed: 5/27/2021 3:25 PM EDT
Proposed Effective: 5/27/2021 12:00 AM EST
Proposed Expiration: 5/27/2022 12:00 AM EST

Commission: 0.00

Quoted By: Bryce Maher
Berkshire Hathaway Homestate
1314 Douglas St
Omaha, NE 68102bmaher@bhhc.com
Producer: Garzor Insurance, LLC
4369 Hunters Park Lane
Orlando, FL 32837
Phone - (321) 206-8035
Fax - (321) 251-7720

DOT #: Unknown

MC #: Unknown

<u>Symbol</u>	<u>Coverage</u>	<u>Limit (\$)</u>	<u>Premium (\$)</u>
7	Liability	1,000,000 CSL	21,113
7	UM - BIPD	75,000 CSL	1,133
7	UIM - BIPD	N/A	N/A
7	Medical Payments	1,000	321
7	Physical Damage	See Specific Unit	2,781
	Total Ins Value	30,000	
Total			\$25,348.00

Revision: 2SC2020R02

Vehicle Information

BHHC-Rate Version: 8.7.4760.1522

<u>Unit</u>	<u>Liability</u>	<u>UM</u>	<u>UIM</u>	<u>Med Pay</u>	<u>Phys Dam</u>	<u>Cargo/ In-Tow</u>	<u>Al/Lessor</u>	<u>Unit Sub Total</u>
1 2018 DODGE GRAND CARAVAN (79102)	21,113	1,133	N/A	321	2,781	N/A	N/A	25,348
Comp/Coll: \$30,000 Deductible: 1,000/1,000								
Radius: Up to 25 Miles								

**Berkshire Hathaway**
HOMESTATE COMPANIES

MAZYCK MEDICAL TRANSPORT LLC

Quote #: 11740580

Terms and Conditions

This quote is being offered subject to the following terms and conditions. The Company disclaims any responsibility for your failure to reconcile the original application with coverage quoted herein. Failure to comply with the following terms may result in cancellation.

Terms:

- 12.5% Commission
- All New Drivers must meet driver guidelines.
- Compliance with UM/UIM Limit Requirements.
- No filings
- No Transportation of Hazardous Materials, Garbage, Contaminated Soil, Asbestos, or similar exposures.
- Operation: NEMT
- Prompt reporting of all new drivers.
- Subject to 100% of operations within SC
- Subject to 100% of rides being prearranged at least 24 hours in advance
- Subject to max of 2 passengers
- Subject to no cruising for fares
- Subject to no filings or MCS-90.
- Subject to no prior losses
- Subject to no Uber, Lyft, taxi, or similar exposure
- Subject to the scheduled power unit having permanently installed disability equipment

Unless Otherwise specified, all conditions listed below must be satisfied within 30 days of binding coverage. Failure to satisfy all conditions within the applicable timeframes may result in cancellation.

Conditions:

- Completed and Signed Selection/Rejection forms as required by state law.
- Radius: 100% of operations within 25 miles; inform if different

Quote is valid through: 06/24/2021

Disclosure Statement: The premium for this account includes a commission that is within the terms of your normal commission schedule included within the provisions of your Agency Agreement. If your agency contract includes a Profit Sharing Agreement, this policy may or may not be included in that profit sharing plan. It's unclear at this time whether you will be eligible for profit sharing or whether this individual account will increase or decrease any profit sharing payout as the loss ratio is undetermined at this time and any payments are not guaranteed.

This is **NOT** a binder of insurance. Company must be notified prior to Binding Coverage.

Schedule of Forms & Endorsements

CA 0001 (10/2013) Business Auto Coverage Form
CA 0150 (05/2017) South Carolina Changes
CA 2018 (10/2013) Professional Services Not Covered
CA 2119 (12/2013) South Carolina Uninsured Motorists Coverage
CA 2402 (10/2013) Public Transportation Autos
CA 9958 (04/2014) South Carolina Auto Medical Payments Coverage
IL 0017 (11/1998) Common Policy Conditions
IL 0021 (09/2008) Nuclear Energy Liability Exclusion Endorsement (Broad Form)
M 3912b (08/2001) Stated Amount Insurance
M 4566a (11/1999) Motor Vehicle Liability Insurance Identification Card
M 4572 (12/1994) Schedule of Forms and Endorsements at Policy Inception
M 4803 (02/1998) Abuse or Molestation Exclusion
M 4959a (03/2002) Schedule of Covered Autos
M 5332a (12/2009) South Carolina Changes - Cancellation and Nonrenewal
M 5398 (03/2009) South Carolina Important Notice - Uninsured Motorist
M 5479 (04/2010) Towing and Storing Costs
M 5603 (03/2017) Policy Jacket
M 5605 (02/2011) Business Auto Coverage Declarations
M 5623 (04/2011) Application of Policy - Financial Responsibility
M 5749 (01/2013) Underinsured Motorists Coverage Amendatory Endorsement
M 5872 (04/2016) Changes to Common Policy Conditions - Cancellation



Berkshire Hathaway HOMESTATE COMPANIES

M-5861 01/2021

1314 Douglas Street, Suite #1300, Omaha, NE 68102-1944 | Phone: 800.488.2930 | BHHC.com

05/27/2021

MAZYCK MEDICAL TRANSPORT LLC

342 Allans Mill Dr

Columbia, SC 29223

Billing services:

1-877-680-2442

Monday - Friday

7:00 AM - 7:00 PM Central Time

Claim reporting:

1-800-356-5750

24 hours a day

7 days a week

RE: Insurance Quote: 11740580

Proposed Term: 5/27/2021 - 5/27/2022

Writing Company: Berkshire Hathaway Homestate
Insurance Company**To MAZYCK MEDICAL TRANSPORT LLC:**

Berkshire Hathaway Homestate Companies may use consumer information obtained from consumer reporting agencies to help determine the terms, conditions, or premium of our insurance policies. Specifically, we used the insurance score derived from consumer data in the LexisNexis Attract for Business Owners Underwriting Model 3.1 to underwrite this Insurance Quote. Based on the information from LexisNexis, we have not offered the most favorable terms, conditions, or premium available.¹

LexisNexis did not make this decision and is unable to provide the specific reason(s) for this action.

This insurance score was provided by LexisNexis based on consumer data for the following individual(s)

Name: Jasmine Mażyck
Address: 342 Allans Mill Dr
Columbia, SC 29223

This individual may obtain a free copy of the consumer report from LexisNexis by contacting LexisNexis within 60 days of this notice:

LexisNexis Consumer Center
P.O. Box 105108 1-800-456-6004
Atlanta, Georgia 30348-5108 www.consumerdisclosure.com

This individual may also dispute the accuracy or completeness of information contained in the consumer report. If the individual disputes information contained in the consumer report, and that dispute results in the correction or deletion of information in the consumer report, you may request that we reevaluate the underwriting of this Insurance Quote to determine if you qualify for more favorable terms, conditions, or premium.

Regards,

Berkshire Hathaway Homestate Insurance Company

¹

Please be advised that whether this action is deemed an "adverse action" under the Fair Credit Reporting Act (15 U.S.C. § 1681) depends on the relevant law of the applicable jurisdiction.

Berkshire Hathaway Homestate Insurance Company

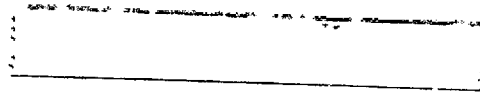
M-5861 01/2021

Driver Information for MAZYCK MEDICAL TRANSPORT LLC

BHHC-Rate for South Carolina

Berkshire Hathaway Homestate Insurance Company

Quote #: 11740580



<u>Driver</u>

1 Jasmine Mazyck

Date of Birth	License Class
---------------	---------------



OFFER OF OPTIONAL ADDITIONAL UNINSURED MOTORIST COVERAGE AND OPTIONAL UNDERINSURED MOTORIST COVERAGE

I. **EXPLANATION OF COVERAGES**

The State of South Carolina's automobile insurance laws now allow any insurance company to refuse to underwrite your automobile liability insurance coverage. That refusal may be based upon a number of reasons. **Automobile liability insurance coverage** pays other motor vehicle drivers and their passengers whom you damage for the damages which you cause and for which you are legally responsible. There are two types of automobile liability insurance coverage: bodily injury and property damage. **Bodily injury coverage** is a coverage which pays people upon whom your motor vehicle inflicts bodily injury. **Property damage coverage** is a coverage which pays people for damages which your automobile causes to their motor vehicles or property.

Once any insurance company makes the business decision to underwrite your automobile liability insurance coverage, then it must provide to you at least \$25,000.00 of bodily injury coverage for each person whom you may injure in any single accident and \$50,000.00 of bodily injury coverage for two or more people whom you may injure in any single accident. The insurance company must also provide to you at least \$25,000.00 in property damage coverage for each accident which you may cause. You may have seen these limits described as \$25,000/\$50,000/\$25,000 or 25/50/25. These limits are commonly known as **minimum limits**. If you purchase automobile liability insurance, then, in order to drive your automobile upon the roads of this State, you must have at least minimum limits.

There is no requirement under the laws of this State that an insurance company which underwrites your minimum limits of \$25,000/\$50,000/\$25,000 must also agree to underwrite higher than those minimum limits of automobile liability insurance coverage for you. If your insurance company does agree to offer to you more than the minimum limits, then you will be required to pay an increased automobile insurance premium for those increased limits of protection.

In addition, under this State's insurance laws, once an insurance company agrees to underwrite your automobile liability insurance coverage, you must be offered, at your option, two additional automobile insurance coverages which will protect *you* in the event *you* are damaged in an automobile accident by an at-fault automobile driver who either has no automobile insurance or whose automobile insurance liability limits are less than the damages which you suffer in that accident. These coverages are legally termed additional uninsured motorist coverage and underinsured motorist coverage. You may see them referred to within your automobile insurance policy as UM and UIM. If you decide to purchase either of these two optional coverages, then you will be required to pay an additional automobile insurance premium for each of these additional coverages.

Uninsured motorist coverage compensates you, or other persons insured under your automobile insurance policy, for amounts which you may be legally entitled to collect as damages from an owner or operator of an at-fault uninsured motor vehicle. An uninsured motor vehicle is a motor vehicle which either has no liability insurance coverage or is operated by a hit-and-run driver. By law, your automobile insurance policy automatically must provide uninsured motorist coverage of \$25,000/\$50,000/\$25,000. All uninsured motorist coverages provide for a \$200 deductible for uninsured property damage claims.

You also have the right to buy **additional** uninsured motorist coverage, in various limits, up to the limits of the liability coverage which you will carry under your automobile insurance policy. Some of the more commonly-sold limits of additional uninsured motorist coverage, together with the additional premiums which you will be charged, have been printed by your insurance company upon this form. If there are other limits in which you are interested, but which are not shown upon this form, then fill in those limits in the blanks provided. If your insurance company is allowed to market those limits within this State, then your insurance agent will fill in the amounts of increased premium.

Quote #: 11740580

Underinsured motorist coverage compensates you, or other persons insured under your automobile insurance policy, for amounts which you may be legally entitled to collect as damages from an owner or operator of an at-fault underinsured motor vehicle. An underinsured motor vehicle is a motor vehicle which is covered by some form of liability insurance, but that liability insurance coverage is not sufficient to fully compensate you for your damages.

Your automobile insurance policy does not automatically provide any underinsured motorist coverage.

However, you have the right to buy underinsured motorist coverage in limits up to the limits of liability coverage which you will carry under your automobile insurance policy. Some of the more commonly-sold limits of underinsured motorist coverage, together with the additional premiums you will be charged, have been printed by your insurance company upon this form. If there are other limits in which you are interested, but which are not shown upon this form, then fill in those limits in the blanks provided. If your insurance company is allowed to market those limits within this State, then your insurance agent will fill in the amounts of increased premium.

It is important that you understand that, *if you reject* either one of these coverages upon this form and if you are involved in an automobile accident, then this form may be used by your insurance company as *evidence against you* if it denies your claim for additional uninsured motorist coverage or underinsured motorist coverage.

If you do not complete this form and return it to your insurance company or to your insurance agent within 30 days from your receipt of this form, then the law requires that additional uninsured motorist coverage and underinsured motorist coverage, in the same limits as the automobile liability insurance which you purchase, must be automatically added on to your automobile insurance policy. You will be required to pay an additional premium for each of these two coverages. If you do not pay that additional premium, then your automobile insurance policy may be cancelled.

In the future, if you wish to increase or to decrease your limits either of additional uninsured motorist coverage or of underinsured motorist coverage, *you* must then contact either your insurance agent or your insurance company. You will not be presented with another copy of this form by your insurance agent or by your insurance company upon renewal of your automobile liability insurance policy. You will not be presented with another copy of this form by your insurance agent or by your current insurance company when you extend, change, supersede, or replace your automobile liability insurance policy.

Please read this form carefully. Your insurance agent or your insurance company *must* answer any questions which you may have. If you have any further questions, then you should contact the State of South Carolina Department of Insurance. Its address and telephone number are:

Office of Consumer Services
State of South Carolina Department of Insurance
Capitol Center
1201 Main Street, Suite 1000
Post Office Box 100105
Columbia, South Carolina 29202-3105
(803) 737-6180
(800) 768-3467
E-mail Address: consumers@doi.sc.gov

MAZYCK MEDICAL TRANSPORT LLC

M-5638 (01/2019)

Berkshire Hathaway Homestate Insurance Company

Quote #: 11740580

II. OFFER OF ADDITIONAL UNINSURED MOTORIST COVERAGE

\$25,000 / \$50,000 / \$25,000 minimum limits of Uninsured Motorist Coverage are automatically provided by your Policy.

<u>Additional Limits of Coverage</u>	<u>Premium Cost</u>
\$30,000/\$60,000/\$25,000	\$ 921
\$50,000/\$100,000/\$25,000	\$ 1,124
\$50,000/\$100,000/\$50,000	\$ 1,148
Your Policy's Liability Coverage Limits:	
\$1,000,000	\$ 3,727

☐ I reject additional Uninsured Motorist Coverage

☒ I select additional Uninsured Motorist Coverage at the following limits: \$75,000 CSL

III. OFFER OF OPTIONAL UNDERINSURED MOTORIST COVERAGE

<u>Limits of Coverage</u>	<u>Premium Cost</u>
\$25,000/\$50,000/\$25,000	\$ 1,278
\$30,000/\$60,000/\$25,000	\$ 1,369
\$50,000/\$100,000/\$25,000	\$ 1,672
\$50,000/\$100,000/\$50,000	\$ 1,707
Your Policy's Liability Coverage Limits:	
\$1,000,000	\$ 5,542

☒ I reject optional Underinsured Motorist Coverage

☐ I select optional Underinsured Motorist Coverage at the following limits _____

IV. APPLICANT'S ACKNOWLEDGEMENT

By my signature, I acknowledge that I have read -- or I have had read to me -- the above explanations and offers of additional uninsured motorist coverage and underinsured motorist coverage. I have indicated whether or not I wish to purchase each coverage in the spaces provided. I understand that the above explanations of these coverages are intended only to be brief descriptions of additional uninsured motorist coverage and underinsured motorist coverage, and that payment of benefits under either of these coverages is subject both to the terms and conditions of my automobile insurance policy and to the State of South Carolina's laws.

Type or Print Your Name: _____

Your Signature: _____

Your Address: _____

Today's Date: _____

M-5638 (01/2019)

Page 3 of 3



PO Box 31145 • Omaha, NE 68131
bhhc.com

Direct Bill Payment Plan Options

Date: 05/27/2021

Billing Services:
1-877-680-2442

7:00 AM-7:00 PM Central Time, Mon-Fri

billing@bhhc.com

Applicant Name: **MAZYCK MEDICAL TRANSPORT LLC**

Quote Number: 11740580

Indicated Premium: \$ 25,348.00 (includes government fees and assessments, if applicable)

Payment Plans:	11-Pay	6-Pay	4-Pay	2-Pay	Full Pay
Down Payment					
Due at Binding	\$5,070.00	\$5,070.00	\$6,337.00	\$12,674.00	\$25,348.00
Installments*					
Month 1	\$2,027.44	\$4,055.28			
Month 2	\$2,027.84		\$6,337.00		
Month 3	\$2,027.84	\$4,055.68			
Month 4	\$2,027.84				
Month 5	\$2,027.84	\$4,055.68	\$6,337.00	\$12,674.00	
Month 6	\$2,027.84				
Month 7	\$2,027.84	\$4,055.68			
Month 8	\$2,027.84		\$6,337.00		
Month 9	\$2,027.84	\$4,055.68			
Month 10	\$2,027.84				

*Indicates number of months after policy effective date.

Direct Bill policies require a down payment at the time of binding. The down payment may be submitted online from the insured's bank account, credit or debit card during binding. Subsequent installments will be due on the same calendar day as the effective date of the policy. Please see the payment plan options above.

Recurring Payments



Recurring payments are a convenient and secure option to automatically deduct insurance payments from a bank account, credit card, or debit card on the scheduled due date. Enroll by completing the Recurring Payment Authorization form or by calling Billing Services at 1-877-680-2442 7 am - 7 pm Central Time Monday - Friday.



P.O. Box 31145 • Omaha, NE 68131
bhhc.com

Recurring Payments Authorization Form

Billing Services:

1-877-680-2442

7:00 AM - 7:00 PM Central Time, Mon - Fri
billing@bhhc.com

Insured Name: **MAZYCK MEDICAL TRANSPORT LLC**
Quote Number: **11740580**
Agency Name: **Berkshire Hathaway Homestate Companies**

Recurring payments are a convenient and secure option to automatically deduct your insurance payment from your bank account, credit card or debit card on the scheduled due date. When enrolled in recurring payments the installment fee is eliminated, lowering your bill.

Select a Request Type:

Enroll in Recurring Payments ☐

Change Recurring Payments Account ☐

Stop Recurring Payments ☐

(only signature and date required)

Name on Account: _____

Account Holder Address: _____

City/State/ZIP: _____

E-mail Address for Receipts: _____

Enroll using a Checking/Savings Account

Account Type:

Checking Account ☐

Savings Account ☐

Bank Name: _____

Routing Number*: _____

Account Number: _____

*Please note that a routing number has exactly nine digits.

Enroll using a Credit/Debit Card*

Card Type:

Visa ☐

Mastercard ☐

Discover ☐

American Express ☐

Card Number: _____

Expiration Date: _____

*A nominal transaction and reversal may appear on your statement due to our validation process.

Please submit this completed form via one of the following methods:

- FAX to 1-866-897-2393
- MAIL to PO Box 31145, Omaha, NE 68131
- ****E-MAIL WILL NOT BE ACCEPTED****

Please Note: Down payments will not be processed from the information on this form. Down payments may be processed online at the time of binding or by calling Billing Services.

A payment schedule will be mailed to you showing the dates and amounts of your recurring payments. If there is an outstanding bill when you enroll in recurring payments, a one-time payment will be processed on the bill's due date. If a payment date falls on a weekend or holiday, the payment will be drafted on the next business day. Please note that three (3) business days advanced notice is required to change or stop recurring payments.

*** I authorize National Indemnity Company on behalf of Berkshire Hathaway Homestate Companies to initiate automatic payments for premium on my insurance policy and its renewals to my bank account, credit card or debit card. This authority shall remain in effect until I revoke it in writing to the address above, by fax to 1-866-897-2393 or by calling Billing Services. I authorize my financial institution to debit the above designated bank account, credit card or debit card, and understand that I will receive advance notice of any increase in payments which result from endorsements to or renewal of my policy.***

AUTHORIZED SIGNATURE: _____

DATE: _____



Berkshire Hathaway HOMESTATE COMPANIES

Binding Procedures - Commercial Auto

You may bind coverage for an account for which you have received a formal quote, provided there are no additions, alterations or omissions to any of the terms of the coverage requested, by following the instructions included below. Our premium indications are valid for 30 days.

****New Direct Bill Option - Auto, Cargo, or Garage Only****

Direct Bill account coverage will be bound no earlier than the effective time and date the bind is initiated online.

To bind coverage:

You will receive a link from noreply@bhhc.com. Follow the link in the email to our online binding mechanism. You will then have two options:

1) Pay Now

Down payment must be processed through our online system at the time of bind. If valid payment is not received at time of bind, no coverage will be in effect. Please gather payment information (bank routing #, checking account # or credit/debit card #, expiration date and security code) from the insured before starting the bind process.

2) Pay Within Five Days

Your agency will be directly responsible for all earned premium on the policy. If the down payment is not received by us within five (5) calendar days, a notice of cancellation will be issued for nonpayment of premium.

Premium Financed Policies

Note: Premium Financed policies will be run through our Direct Bill mechanism, but will be on a full payment plan. You may choose to pay now and pay the policy premium in full at time of bind, or pay within five days. The insured will be billed and shall be responsible for any additional premium that is endorsed onto the policy. If the insured elects to premium finance the endorsed premium it is the insured's responsibility to contact the premium finance company.

Questions? Contact P&C Client Services at (877) 680-2442

* Commissions will be paid monthly as payments are received. Commission statements and checks are generated at the beginning of each month.

Berkshire Hathaway Homestate Insurance Company • Brookwood Insurance Company • Continental Divide Insurance Company
Cypress Insurance Company • Oak River Insurance Company • Redwood Fire and Casualty Insurance Company

THE LANGUAGE USED IN THIS DOCUMENT DOES NOT CREATE AN EMPLOYMENT CONTRACT BETWEEN THE EMPLOYEE AND THE AGENCY. THIS DOCUMENT DOES NOT CREATE ANY CONTRACTUAL RIGHTS OR ENTITLEMENTS. THE AGENCY RESERVES THE RIGHT TO REVISE THE CONTENT OF THIS DOCUMENT, IN WHOLE OR IN PART. NO PROMISES OR ASSURANCES, WHETHER WRITTEN OR ORAL, WHICH ARE CONTRARY TO OR INCONSISTENT WITH THE TERMS OF THIS PARAGRAPH CREATE ANY CONTRACT OF EMPLOYMENT.

PERSONNEL DATA

RACE		EDUCATION		COUNTY CODES					
W	White	12	High School Graduate/GED	01	Abbeville	16	Darlington	31	Lee
B	Black/African American	13	Completed one year of college	02	Aiken	17	Dillon	32	Lexington
H	Hispanic/Latino	14	Completed two years of college	03	Allendale	18	Dorchester	33	McCormick
O	Asian	15	Completed three years of college	04	Anderson	19	Edgefield	34	Marion
A	American Indian/Alaska Native	16	Associate's degree	05	Bamberg	20	Fairfield	35	Marlboro
N	Native Hawaiian/Other Pacific Islander	17	Bachelor's degree	06	Barnwell	21	Florence	36	Newberry
T	Two or More Races	18	Master's degree	07	Beaufort	22	Georgetown	37	Oconee
		19	Doctorate	08	Berkeley	23	Greenville	38	Orangeburg
		20	Juris Doctorate	09	Calhoun	24	Greenwood	39	Pickens
		21	Medical Doctorate	10	Charleston	25	Hampton	40	Richland
				11	Cherokee	26	Horry	41	Saluda
				12	Chester	27	Jasper	42	Spartanburg
				13	Chesterfield	28	Kershaw	43	Sumter
				14	Clarendon	29	Lancaster	44	Union
				15	Colleton	30	Laurens	45	Williamsburg
								46	York

EMPLOYEE INFORMATION (Please use Codes listed above where applicable)

EMPLOYEE'S NAME

HOME ADDRESS CITY STATE ZIP CODE COUNTY CODE

RACE SEX MARITAL STATUS EDUCATION

DATE OF BIRTH DRIVERS LICENSE NUMBER CLASS STATE EXPIRATION DATE

HOME PHONE NUMBER

PRIOR STATE SERVICE (AGENCY & DATES: FROM/TO)

Have you ever been a TERI employee or are you a retired member of the Public Employee Benefit Authority or PEBA (formerly the South Carolina Retirement Systems)?

EMERGENCY CONTACT INFORMATION (Employee is responsible for updating this information as changes occur via MySCEmployee.)

1.	RELATIONSHIP	HOME PHONE: _____ WORK PHONE: _____
ADDRESS		
2.	RELATIONSHIP	HOME PHONE: _____ WORK PHONE: _____
ADDRESS		

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H	Hispanic/Latino	14	Completed two years of college	03	Allendale	18	Dorchester	33	McCormick
O	Asian	15	Completed three years of college	04	Anderson	19	Edgefield	34	Marion
A	American Indian/Alaska Native	16	Associate's degree	05	Bamberg	20	Fairfield	35	Marlboro
N	Native Hawaiian/Other Pacific Islander	17	Bachelor's degree	06	Barnwell	21	Florence	36	Newberry
T	Two or More Races	18	Master's degree	07	Beaufort	22	Georgetown	37	Oconee
		19	Doctorate	08	Berkeley	23	Greenville	38	Orangeburg
		20	Juris Doctorate	09	Calhoun	24	Greenwood	39	Pickens
		21	Medical Doctorate	10	Charleston	25	Hampton	40	Richland
				11	Cherokee	26	Horry	41	Saluda
				12	Chester	27	Jasper	42	Spartanburg
				13	Chesterfield	28	Kershaw	43	Sumter
				14	Clarendon	29	Lancaster	44	Union
				15	Colleton	30	Laurens	45	Williamsburg
								46	York

EMPLOYEE INFORMATION (Please use Codes listed above where applicable)

EMPLOYEE'S NAME

HOME ADDRESS CITY STATE ZIP CODE COUNTY CODE

RACE SEX MARITAL STATUS EDUCATION

DATE OF BIRTH DRIVERS LICENSE NUMBER CLASS STATE EXPIRATION DATE

HOME PHONE NUMBER

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ADDRESS		